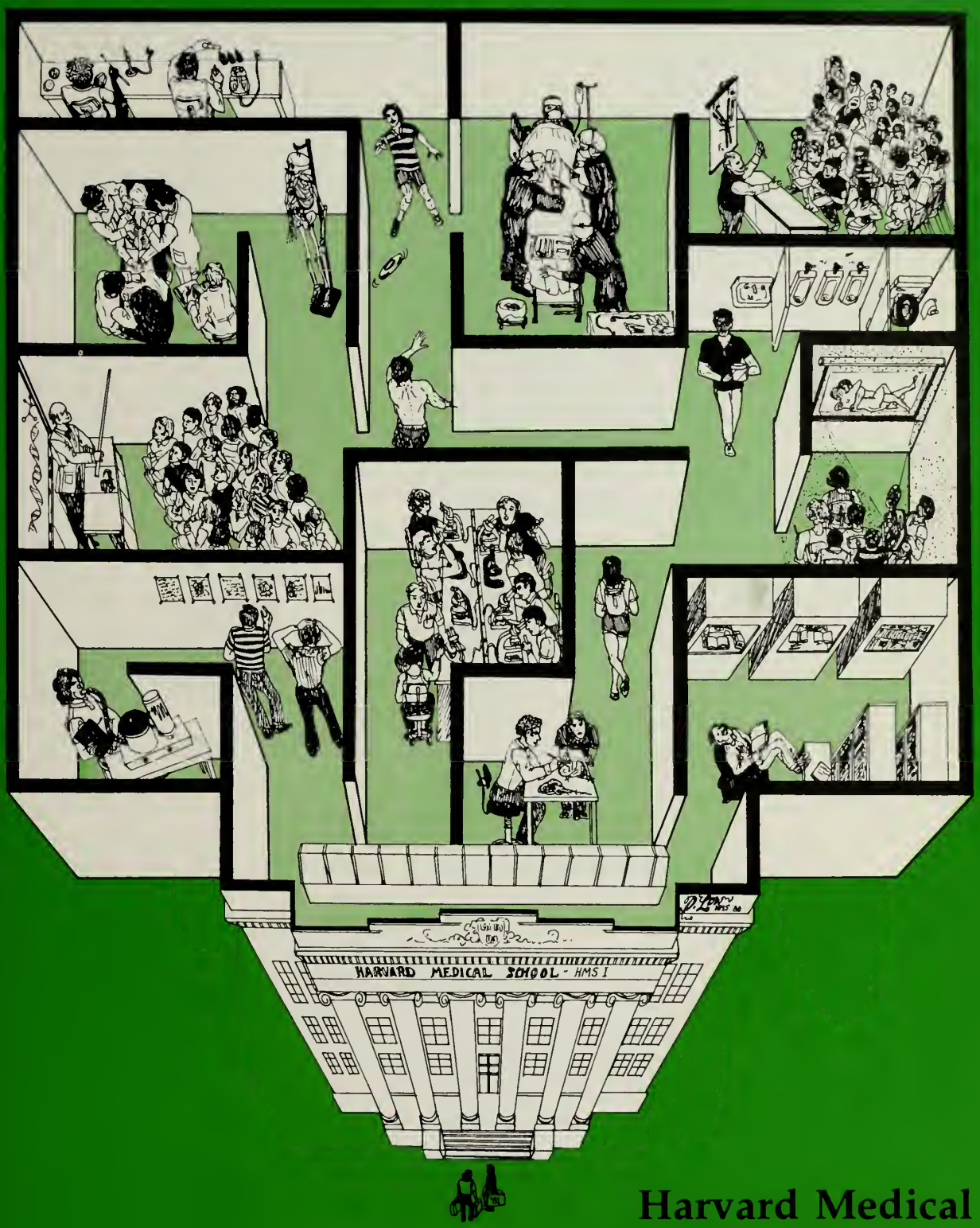

Harvard Medical Alumni Bulletin

September/October 1977

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Harvard Medical Alumni Bulletin

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The *Harvard Medical Alumni Bulletin* is published bi-monthly at 25 Shattuck St., Boston, Mass. 02115. Third class postage paid at Burlington, Vermont.

Cover: We borrowed the cover of the orientation booklet produced by a number of industrious second year students. Its contents range from a list of administrative offices and student organizations to an interview with Dean Tosteson and evaluations of the first year's basic science courses, including, as might be expected, candid student critiques. This venture was edited by Andy Marks '80 and the artwork was done by David Low '80.

Credits: pp. 1, 16-20, 22-30, Christopher Morrow; p. 4, Deborah Taylor; p. 10, Bradford Herzog; p. 21, Diane Andronica; p. 40, courtesy of Dr. Lewis Thomas.

Members of the Class of 1977 pledging themselves to the oath of their profession. *For the full account of the day's ceremonies, please turn to page 16.*

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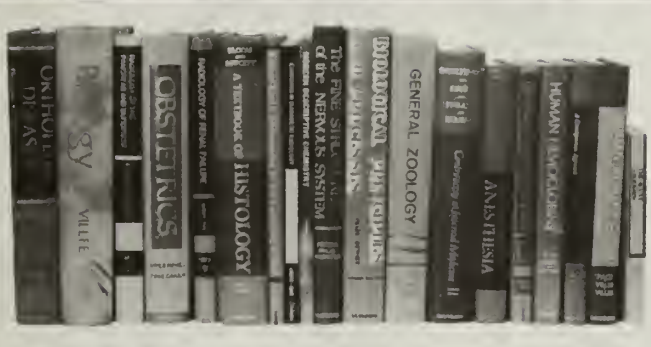

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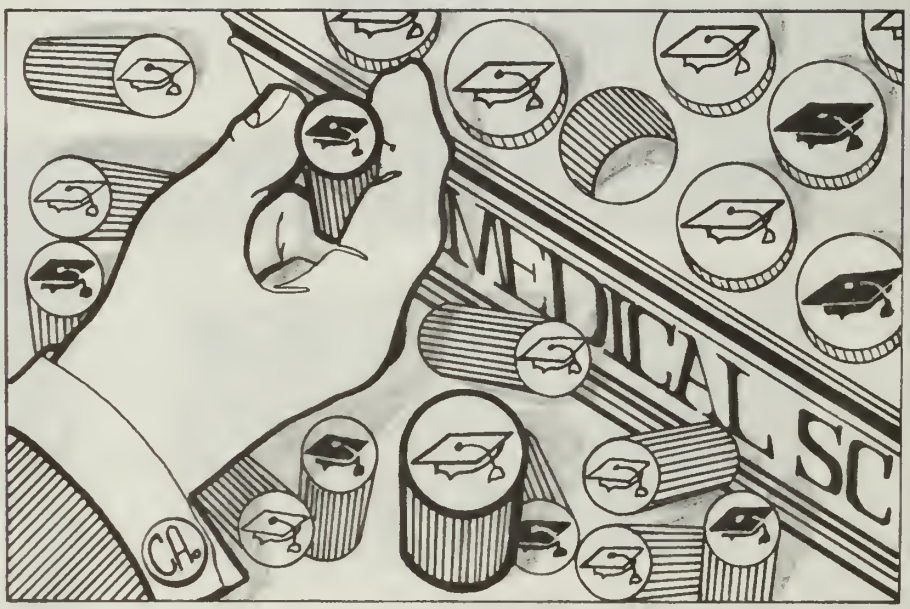
Overview

The Bakke case: minority admissions in the balance

"... Nor shall any state deny to any person within its jurisdiction the equal protection of its laws," reads the Fourteenth Amendment. Is it, then, constitutional for state university admissions policies to give favorable weight to minority status as one of the factors considered in choosing among qualified applicants? In an *amici curiae* brief filed jointly with Columbia University, Stanford University, and the University of Pennsylvania in the case *Regents of the University of California vs. Allan Bakke*, Harvard University argues that it is indeed constitutional. The US Supreme Court has agreed to rule on the case, and its decision, according to Harvard General Counsel Daniel Steiner, "may be as significant for our society as was the decision in 1954 in *Brown vs. Board of Education.*"



Allan P. Bakke, a white civil engineer in his late thirties, brought suit after his application for admission to the medical school of the University of California at Davis was rejected in 1973 and again in 1974. Thus far, his contention that he was denied his Fourteenth Amendment rights has been upheld by both the original California trial court, and by the state supreme court.

An earlier opportunity to rule on the controversial issue of so-called reverse discrimination was passed up by the highest court in the well-publicized case of Marco De Funis, Jr., who had protested denial of admission to the law school of the University of Washington. On the order of the trial court judge, the school admitted De Funis, while taking the case to appeal at the state level — which it won. By the time the wheels of justice had taken De Funis's appeal of the second ruling to the Supreme Court, he was two months away from his law degree. On that basis, the Court declared the case "moot". Bakke, however, was not admitted to medical school, pending review of his case.

Hinging on the Bakke case decision may be the entire future of what has come to be called affirmative action, that is, the policy of being "color conscious" in a positive sense, in the short run, in university admissions and in employment — in order to achieve the goal of being "color blind" in the long run. At a meeting in the Countway Library on May 2, Daniel Steiner outlined the history of struggles to eliminate racial discrimination in our society, and the reasoning behind Harvard's position. Early civil rights efforts in the '30s, '40s and '50s, he pointed out, "focused on trying to make our society color-blind" — pushing for the enactment, for instance, of laws forbidding an employer or a university from asking the race of an applicant. But such measures proved to be "a false hope"; they did not significantly widen the participation of racial minorities in higher education or in the mainstream of the economy.

At Harvard College, for instance, despite the absence of any explicitly discriminatory admissions policy, until the late '60s black enrollment remained at the level of two to eight members in each class of 1,100, and black applicants were few. Harvard finally recognized that both active recruitment of blacks and a favorably "color conscious" admissions policy were necessary to redress the balance.

Among the arguments put forward by the *amici curiae* brief, which was submitted June 7, is that affirmative action does meet the traditional legal test applied to laws which make distinctions

among citizens: that there be a "compelling state interest" at stake. First, the brief argues, racial diversity in a university's student body makes for a richer — and more realistic — educational experience for all involved. Observed Steiner, "If you take the very case we're talking about, the Bakke case, and just imagine a discussion of it in a law school class . . . the discussion of the constitutional, social, political issues involved . . . is likely to be different, and I think better, with a diverse student body in the class." Second, the brief contends that universities perform the social function of supplying trained leaders and professionals, and that it is a compelling state interest that these roles be filled by a mix of people representative of the society as a whole.

Steiner added that the brief also "tries to impress upon the Court the dangers of greater intervention by the judiciary into the educational processes of universities," and asks that educators be left free to (in the words of the brief) "search in good faith for solutions" to social problems.

Under the wording of the Fourteenth Amendment, the Supreme Court's decision will apply directly only to state institutions; however, private ones like Harvard may be indirectly affected, according to Steiner. As a recipient of federal contracts, Harvard is covered by laws prohibiting both racial and sex discrimination in education and in employment. A broadly stated decision in Bakke's favor could limit all anti-discrimination laws to the old negative, "color blind" and "sex blind" interpretation, rather than the affirmative action approach to which the country has recently made a commitment.

A narrowly couched pro-Bakke ruling, however, might restrict merely the types of procedures used in affirmative action. The University of California at Davis Medical School has a quota reserving sixteen places of each class of one hundred for "disadvantaged" applicants — who thus far have all been black — plus a lower grade point average cut-off point for this group. The Court might strike down such measures, while leaving intact the more flexible and subjective methods employed at Harvard Medical School and elsewhere.

Unfounded, Steiner said, are the fears of some white ethnic organizations that a ruling upholding the University of California's procedures might later be interpreted as sanctioning maximum quotas for minorities who may now be over-represented in universities as compared to their percentage in the general population. There is a legal distinction to be made, he said, between quotas or other policies designed to help certain groups by setting minimum goals, and those which invidiously discriminate against a group, seeking to limit its opportunities.

In the discussion that followed Steiner's talk at the Countway, Harold Bursztajn '77 offered a broader perspective on the issue of affirmative action. He pointed out that policies weighted in favor of blacks tend to place blacks and low income whites in competition for a seemingly limited supply of places, both in higher education and in employment. Poor and disadvantaged people of all races are natural allies, he said, and should join together to fight for enough opportunities for all. A black woman in the audience disagreed, arguing that the disadvantages experienced by blacks in this country are unique, and require unique remedies.

Whether the opinion of the Supreme Court will address this larger issue remains to be seen. The decision is not expected before June.

Primary Care Prognosis

I. Residencies multiply at Harvard hospitals

Over the past three years, training in primary care has assumed a steadily expanding role at Harvard hospitals. Forty residents in primary care are now in training at the Beth Israel, Massachusetts General, Peter Bent Brigham, Cambridge, Mt. Auburn and Children's hospitals; twenty-seven have already completed a three year program, and a total of fifty-three will be involved by July 1979. This commitment and continued growth in the number of primary care residencies has been made possible by grants from the Robert Wood Johnson Foundation.

How does a residency in primary care differ from one in internal medicine? Robert Lawrence '64, head of the Division of Primary Care and Family Medicine at HMS, explains that the primary care programs place greater emphasis on the effects of family, environment and other psychological and social factors on the health of an individual. The clinical experience is geared to the common problems encountered in primary care practice. In addition to medical training on the hospital ward, "each of the trainees devotes six months of the year to ambulatory rotations," and then receives "additional training in specialties such as office gynecology, common ear-nose-and-throat and ophthalmology, minor orthopedics, dermatology and psychiatry."

The emphasis on psychosocial factors in health is supported by data showing that from twenty to seventy per cent of all patients seeking care from first-contact physicians have complaints closely related to psychological and social disruptions in their lives. "In spite of this," asserts Dr. Lawrence, "medical education at both undergraduate and graduate levels has so neglected this aspect of training that most physicians enter medical practice with little or no education in the most elementary as-

pects of behavior, psychiatry, and personality development as they relate to all illness."

For the outpatient aspect of training, says Dr. Lawrence, "a rich and diverse experience is provided by having ambulatory care facilities in hospitals, neighborhood health centers, prepaid group practice plans, a student health service, and, recently added, rural practice in Vermont and Massachusetts where residents can rotate on an elective basis." Nine local sites are involved in the programs: the Beth Israel Ambulatory Care Program, the Bunker Hill and Chelsea neighborhood health centers of the MGH, the Children's Hospital Primary Care Unit, Dimock Health Center, the MGH, the Pearl Clinic at the Peter Bent Brigham Hospital, Harvard University Health Service, and Harvard Community Health Plan. Since 1975, training in pediatric primary care as well as in internal medicine primary care has been available; a family practice residency program is in the planning stage.

An important spin-off of the development of primary care at the postgraduate level has been the growth of opportunities for primary care experience for HMS undergraduates. Clinical electives for medical students are now offered at three of the ambulatory care sites, and with the help of this year's grant from the Johnson Foundation, more will soon be made available.

II. Team approach in action at PBBH center

A team approach to patient care is the guiding principle of the Primary Care Center, which opened its doors July 1 at the Peter Bent Brigham Hospital. Consisting of four full-time primary care teams — each with its own nurse practitioner, nursing assistant, secretary and several physicians — the new center constitutes a complete reorganization of the hospital's medical clinics. Now patients can choose their own personal physician, and can reach one of the center's doctors on call at any hour of the day or night. About 27,000 patient visits are expected this year.

Training is an important component of the Primary Care Center, involving both physicians and nurse practitioners, as well as hospital administrators from the Harvard School of Public Health. The full-time staff physicians of the center serve as role models and preceptors for the primary care residents, as well as caring for their own patients.

The Primary Care Center is part of a continuing process of developing and expanding primary care facilities, which began in the early 1970s in response to community insistence that the proposed Affiliated Hospitals Center include services that would directly benefit neighborhood residents. Beginning in 1973, the Pearl Primary Care Center at the Brigham pioneered with one patient care team, and achieved a group of highly satisfied patients and a productivity double that of the hospital's general medical clinics. This initial program is now incorporated as one of the four teams that make up the new Primary Care Center. Once the center moves into its quarters in the Affiliated's ambulatory care building — now scheduled for completion in 1982 — it is expected to continue on the team model, but will be able to expand to more than twice its present size.

Overseeing this process of development since 1976 is H. Richard Nesson, M.D., director of the Brigham's division of general medicine and primary care, and of ambulatory and community health services at the Affiliated, who worked with a committee of hospital, trustee, and community representatives in hammering out plans for the new facilities. "I think all of these elements — services, training and research — combine to make a very attractive program for patients, providers, and students," he says. "We are trying to develop a first-class delivery system while providing good training models for providers and administrators. We plan to have a practice setting which will be attractive to all types of patients, providing quality care with dignity. This is an unusual program and we have generated a lot of interest."

The center's staff physicians, who are also on the Medical School faculty, are Drs. William Branch, Ralph Friedin, Matthew Liang '69, H. Richard Nesson, R. Kent Sargent '73, Arthur Siegel '67, Marshall Wolf '63 and Beverly Woo.

Countway films feature medical personages

Four distinguished alumni, Maxwell Finland '26, Samuel A. Levine '14, John Rock '18, and Harvey Cushing '95 will be featured in this year's Leaders in American Medicine film series at the Countway Library. The series, which combines films and panel discussions to achieve a rounded view of each physician's career, is sponsored by Tufts, Boston University and Brown medical schools, the Benjamin Waterhouse Medical History Society, and the Boston Medical Library. This season's first presentation, in September, focused on the life of Leo G. Rigler, M.D. The schedule for the rest of the year is:

Maxwell Finland '26, George Richards Minot Professor of Medicine, Emeritus, HMS, November 9, 1977.

Discussants: Edward H. Kass, M.D., William Ellery Channing Professor of Medicine, HMS; John Z. Bowers, M.D., president, Josiah Macy, Jr. Foundation, president of Alpha Omega Alpha; Maxwell Finland, M.D.

Samuel A. Levine '14 (1891-1966), clinical professor of medicine, emeritus, HMS, February 15, 1978. *Discussants:* Bernard Lown, M.D., professor of cardiology in nutrition in the faculty of public health, Harvard; Daniel S. Bernstein, M.D., clinical professor of medicine and associate dean for hospital affiliations and continuing medical education, Boston University School of Medicine.

John Rock '18, clinical professor of gynecology, emeritus, HMS, March 8, 1978. *Discussants:* Celso-Ramón García, M.D., professor of obstetrics and gynecology and William Shippen, Jr. Professor of Human Reproduction, University of Pennsylvania School of medicine; Arthur T. Hertig '30, Shattuck Professor of Pathological Anatomy, Emeritus, HMS; Luigi Mastroianni, Jr., M.D., William Goodell Professor of Obstetrics and Gynecology and chairman, department of obstetrics and gynecology, University of Pennsylvania School of Medicine; John Rock, M.D.

Harvey Cushing '95 (1869-1939), Moseley Professor of Surgery, HMS, surgeon in chief, Peter Bent Brigham Hospital, April 12, 1978. *Discussants:* Elias E. Manuelidis, M.D., professor of pathology and neurology, curator of brain tumor registry, Yale University School of Medicine; William H. Sweet '36, D.Sc., professor of surgery, emeritus, HMS.

All the programs will begin with a half hour for refreshments and conversation, at 4 P.M. The coordinator of these programs is G.E. Gifford, Jr., M.D., associate professor of socio-medical sciences at Boston University School of Medicine, consultant to the historical collections at the Countway, and secretary of the board of trustees of the Boston Medical Library. A grant from the Josiah Macy, Jr. Foundation to the section on the history of medicine of the Boston University School of Medicine provides the funding for the series.

The auditors are coming

Harvard Medical School and School of Public Health will have the government peering over their shoulders during the next year as the Department of Health, Education, and Welfare conducts an audit of over $200 million in federal research funds received by the schools since 1975. According to an HEW spokesman, "the first systematic, comprehensive review" of research spending at Harvard is the result of an allegation by Dr. Phin Cohen, an assistant professor of nutrition at the School of Public Health from 1955-1976, that money from his NIH research grant was used to supplement the funds of other researchers — in violation of federal regulations. The amount in question was $132,000, which Harvard was compelled to replenish in full.

Last year, auditors at the NIH recommended that HEW investigate the management of federal research grants and contracts, although HEW needed the prodding of two Congressmen — Rep. L. H. Fountain (Dem.-N.C.), chairman of the House subcommittee on intergovernmental relations and human resources, and Sen. William Proxmire (Dem.-Wisc.) — before acting upon the matter. In the early 1960s, Rep. Fountain's committee held hearings on improper allocation of NIH research funds. Recently, his committee was involved in hearings on the Conquest of Cancer program, in which Harvard participated, and the subject of Dr. Cohen's charges came to its attention.

According to Daniel Steiner, general counsel for the University, "other universities have been audited by HEW and HEW is now beginning an audit at Harvard. There have been no allegations of wrongdoing on the part of HEW to Harvard. We intend to cooperate fully with the audit." In fact, over the past ten years research spending at Harvard has been audited by HEW "for specialized purposes," according to an HEW official.

The audit will also examine the flow of money from various other federal sources to Harvard, including the National Science Foundation, the Department of Defense, the Environmental Protection Agency, and the National Aeronautics and Space Administration.

Bulletin Bazaar

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Clinical teaching, admissions, financial aid highlight Council discussions

The Harvard Medical Alumni Council held its winter meeting on February 4 and 5, 1977, and its spring meeting on June 1 and 2, 1977. All officers and councillors were present at these meetings with the exception of John Dixon '62, who was absent from the winter meeting, and Frank Austen '54 and Curtis Prout '41, representative to the Associated Harvard Alumni, who were absent from the spring meeting. Dean Robert H. Ebert; Mr. Henry Meadow, Associate Dean for Administration; F. Sargent Cheever '36, Director of Admissions; William Cochran '52, chairman of the Alumni Survey Committee; and Mr. James Pates, Assistant Dean for Student Affairs were guests at these meetings. Dean-designate Daniel C. Tosteson '49 was introduced to the Council at the spring session.

Among the more important items discussed by the Council was the report of the Alumni Survey Committee on the Introduction to Clinical Medicine, which Dr. Cochran presented at the winter meeting along with a number of recommendations for improving the quality of teaching in the course. These recommendations were the result of interviews with students, visits to individual course meetings at the different hospitals, and talks with some of the instructors. The Alumni Council voted to accept the report in February. Upon hearing of this decision, four of the eight coordinators took exception to some of the Survey Committee's conclusions and recommendations and asked to submit their view of the course at their respective hospitals. Therefore, at the spring meeting, a discussion was led by John Mills, M.D., Massachusetts General Hospital; W. Hallowell Churchill, M.D., Peter Bent Brigham Hospital; William Parkes Beetham, Jr., M.D., Lahey Clinic and the New England Deaconess Hospital; and Charles Hatem '66, Mt. Auburn Hospital. The Alumni Council will consider both the modifications proposed by Dr. Mills et. al. and the substance and recommendations of the report by the Alumni Survey Committee at its fall meeting and will provide some advisory comments of its own. It is hoped that all three reports will be published in a future *Alumni Bulletin*.

Dr. Cheever presented an interim report on the admissions season at the winter meeting and a preliminary final report at the spring meeting. The July/August issue of the *Alumni Bulletin* carries the full text of Dr. Cheever's report to the Faculty of Medicine on June 1.

At the winter meeting Mr. Fred Jewett, Dean of Admissions of Harvard College, spoke to the Council about the history and current state of the Schools and Scholarship Committee, comprised of alumni throughout the country who undertook recruitment at particular high schools and subsequently provided interviews for almost all applicants (out of a pool that now numbers 10,500). There is a close liaison and support with the admissions committee staff in Cambridge. The various chairmen of regional alumni groups periodically return to the University for a review of recruitment and admissions procedures, and for feedback on their activities. While structured differently, the Medical School admissions committee has made frequent use of individual alumni interviewers. Therefore the suggestion that we also try to develop some sort of a regional alumni interview system to assist in the laborious interviewing process was discussed at considerable length. Dean Ebert recommended that the regions be large enough to reflect the geographical distribution of the pool, so that alumni interviewers would not become discouraged if their highly recommended candidates were continually rejected back at the home front. Too many regional groups, comprised of relatively small numbers of alumni, he warned, could result in a low yield.

The Harvard Medical School might do well in trying such an experiment in areas where strong alumni clubs are located, such as Seattle, Los Angeles and San Francisco. Due to the appointment of a new Dean as well as a new director of admissions, it was suggested that the alumni office work with the new director to devise a pilot program in one or more of these cities. Admissions committee members would join with such a regional committee in interviewing the top candidates. The goal would be to make the interviewing process more efficient as well as to reduce the expense for applicants who now travel to Boston, and the interview workload for the admissions committee itself. Most important, from the Alumni Council's point of view, would be the greater involvement of alumni in the affairs of the School.

(continued on p. 10)

Dean Tosteson was present for this discussion and asserted that no issue is of greater importance to him or more difficult to solve. He called for the "creative involvement" of alumni in reviewing candidates for admission. Dr. Tosteson then outlined briefly his plans for an administrative group, one of whom is Daniel Federman '53, who has accepted the position of dean for students and alumni. Dr. Federman's purview will include the admissions process and advising students, in addition to interacting with the alumni. At the conclusion of the discussion, the Alumni Council moved to have the record show a strong vote of commendation and appreciation for the dedicated and unselfish service of Dr. Cheever over the past two years.

A light moment in the proceedings occurred when Catherine Wilfert '62, who is on the faculty at Duke, presented Dean Tosteson with a small token of appreciation and welcome — a tee shirt emblazoned with "Harvard — Duke of the North."

Curtis Prout '41, who serves as chairman of the internship advisory committee, offered an analysis of his role at the winter meeting. He sees himself as the students' advocate in "selling" them to the hospitals. There is a pressing need for feedback from residents, and eventually Dr. Prout hopes that a network of interested alumni, particularly program directors, can play an expanding role in helping the Medical School provide the proper recommendations and guidance when students face decisions about their first year of graduate training.

The problems of the Dean's letter were discussed next. Too early a letter will not give full information about the student; too late a letter will put the student somewhat at a disadvantage with applicants from other schools, which send out their letters earlier. The lack of grades makes the evaluation task that much harder. In spite of these concerns, Dr. Prout was pleased to announce that only eight students did not match this year, chiefly because they would not take advice given beforehand as to where they should apply. Langdon Burwell '44, a proponent of primary care, was pleased to note that of the 165 graduates, 120 were going into the primary care specialties, and that this was a considerably higher percentage than usual.

Mr. James Pates, financial aid officer for medical students, presented a profile of the financial aid figures for the incoming first year class. As recently as five years ago there were significantly more unrestricted funds available for scholarships over and above that which was provided from endowment. Since then, however, the amount of scholarship money from both endowment and unrestricted funds has remained at approximately $750,000, even though the cost of the first year of medical school has increased by $2,700 during the same period. Out of the scholarship funds, appropriated by the School, about $250,000 comes from unrestricted gifts, mainly those received by the Alumni Fund. Because of the financial stringency imposed on the School, less unrestricted monies are available, forcing the Financial Aid Committee to reduce the total figure by approximately $100,000 in fiscal 1977-78.

Scholarship funds distributed to the Class of 1981 are around $125,000, as compared to $165,000 for the Class of 1980. Loans will be a minimum of $5,000 for each first year student, with a slight reduction in proportion to any previous indebtedness. Parents will be asked to give all they can, and students will still have to fill a $400 to $500 gap between their minimal needs and the amount that can be provided by various sources of assistance. Term-time employment and seeking more funds from family and friends will become increasingly vital. Even the amount of loan money available will be less than adequate. In 1977-78 it is expected that close to $9,300 will be needed for a viable minimal budget during the first year. The scholarship to loan ratio this year was thirty to seventy per cent; next year the ratio will be twenty-two to seventy-eight per cent. The guaranteed student loan program has increased to a maximum of $15,000 for the entire four years of medical school, and this will help somewhat. Nevertheless,

although students may leave HMS owing upwards of $20,000, because of continued inflation they can repay these debts with cheaper dollars than those they borrowed.

At both the winter and spring meetings, various student representatives were in attendance. There appears to be a new and much more enthusiastic spirit among the students — they are eager for a return to some of the amenities of student life and are seeking a much warmer and closer relationship with both the faculty and the alumni. Of chief concern to these young men and women has been the closure of Vanderbilt Hall dining room. Two factors helped bring this about: the small number of students taking meals there and the increasing costs of dietary employees' wages; there was a net loss of over $120,000 during the last year of University operation in 1975-76.

With the help of the administration, students have tried to implement some stopgap measures such as hiring outside caterers, but none of the innovations has been successful. The students are hoping that some way can be found to reopen the dining room. One idea they proposed would be for a majority of the student body to sign a meal contract. They asked the advice and support of the Council in determining how the educational as well as the social value of Vanderbilt Hall can be restored. It was suggested that possibly the younger faculty members in the quadrangle could be persuaded to take their meals — especially lunch — at Vanderbilt.

Other student interests have been directed toward promoting social functions that faculty and alumni might attend. Two ingenious first year students have instituted a "happy hour" on Friday afternoons, under the auspices of the Vanderbilt Hall "pub," which has done much to further social intercourse between members of the basic science faculty and students. Residents of Vanderbilt are still concerned about its management and maintenance problems. The Alumni Council has discussed this situation in detail and recommends that a committee be formed to discuss with the administration of HMS ways in which better monitoring and permanent management of Vanderbilt might be achieved, so that the students feel comfortable, but also understand the basic rules and regulations that make for living in a civilized community.

Mr. Sam Lewis, director of development, presented some high points of the financial picture during the Ebert years. Total expenses for the first year of Dr. Ebert's administration in 1965-66 were $22,878,000, which by 1975-76 had risen to $47,607,000. During this period, all gifts received from private sources totaled $88,600,000, divided about evenly between current use (slightly more) and capital gifts. The Alumni Fund received $184,000 with 62% participation in 1965-66, as compared to $415,800 in 1975-76 with 52% participation. It was also announced that the Robert H. Ebert Teaching Fund, started unbeknownst to the Dean more than one and a half years prior to his retirement, had reached the sum of $322,000 from some 219 persons. A brochure describing the goals of the Ebert fund was distributed to Council members; alumni have not been solicited, but obviously any alumnus/a who wishes to can donate to the fund. Dr. Walter presented preliminary figures on alumni giving for 1976-77, and expressed the hope that by the end of the fiscal year the total would exceed $700,000, setting a new record.

In reporting on the *Harvard Medical Alumni Bulletin,* Dr. Richardson said that 1976-77 has been a good year. Ms. Miller and Ms. Frankfeldt perform their duties with ever-increasing expertise and flair. The *Bulletin* received two awards in 1977 from the Council for the Advancement and Support of Education — an exceptional achievement award for the poetry issue and a citation for the cover design of the 1976 alumni and class day issue. The book based on the *Alumni Bulletin* issue on the *Physician Signers of the Declaration of Independence* has received superb reviews in a number of journals.

At his last meeting with the Alumni Council, Dean Ebert thanked the Harvard Medical School Alumni Association for the support they had given him. He then offered some thoughts for the Council to consider in the future. He felt that the pentad system has markedly improved the structure of the Council, and wondered whether the presidency should not be for two years rather than one, to assure better continuity and productivity. He also speculated that perhaps active or emeriti senior faculty should not serve as president of the Alumni Association, especially since current faculty might well have conflicting loyalties in representing two constitutencies. Dr. Ebert also commented that in the future the dean might want to use the president as a sounding board for new ideas and programs and that this would be a much more objective process if he or she were not on the faculty as well.

Finally, the Dean discussed the review mechanisms at the Harvard Medical School and listed the four entities: the Visiting Committee to the Medical School and the School of Dental Medicine, the Visiting Committee to the Division of Medical Sciences, ad hoc committees to review specific departments and programs at the Medical School, and the Alumni Survey Committee. He emphasized that each serves a specific purpose. The first three review groups are more or less guided by the Dean, while the Alumni Council generates the agenda for the Survey Committee. Dr. Ebert suggested that the Dean, the president of the Council, and the Council itself might spend more time discussing the agenda for the Alumni Survey Committee. The Alumni Council, he said, should understand that it is not a governing body, but rather an advisory group to the Dean and that "alumni power" really means alumni involvement. The Council should be a vehicle for informing the alumni about the School. Dr. Ebert assured the Council that his remarks were not intended to be critical of their work. He recognized their singular commitment to the Harvard Medical School and commended their accomplishments.

In conclusion, the Council, again without the Dean's knowledge, voted him a regular alumnus and presented him with a certificate to this effect. In addition, all the alumni who served on the Alumni Council during the tenure of Dean Robert H. Ebert contributed to the purchase of a handsome silver coffee tray, which was inscribed with Dr. Ebert's name on the front, and their signatures on the back. The tray was presented to the Dean on Alumni Day.

Perry J. Culver '41
Director of Alumni Relations

PROMOTIONS

Professor

Douglas F. Adams: radiology at the Peter Bent Brigham Hospital
James A. Belli: radiation therapy at the Joint Center for Radiation Therapy
John J. Collins, Jr.: surgery at the PBBH
Harold F. Dvorak '63: pathology at the Massachusetts General Hospital
Ronald D. Hunt: comparative pathology at the New England Regional Primate Research Center
Stephen H. Robinson '58: medicine at the Beth Israel Hospital
Stuart F. Schlossman: medicine
Alfred Stanton: psychiatry
James L. Tullis: medicine at the New England Deaconess Hospital
Nicholas T. Zervas: surgery

Clinical Professor

H. Thomas Ballantine: surgery
Martin A. Berezin: psychiatry
Anne P. Forbes: medicine

Associate Professor with Tenure

H. Franklin Bunn: medicine

Senior Associate

George Szabo: oral biology and pathophysiology (anatomy)

Associate Professor

Mathea R. Allansmith: ophthalmology
Karoly Balogh: pathology at the NEDH
Herbert Benson '61: medicine at the BIH
Oscar H. L. Bing: medicine
William L. Chick: medicine
Martin E. Dorf: pathology
Martin Dym: anatomy
Harvey Eisenberg: radiology at the BIH
Kenneth E. Fellows: radiology at the Children's Hospital Medical Center
David G. Fromm: surgery
Robert M. Glickman '64: medicine
John G. Hildebrand: neurobiology
Lewis Landsberg: medicine at the BIH
E. Regis McFadden, Jr.: medicine at the PBBH
Robert C. Moellering, Jr. '62: medicine at the MGH
Gordon T. Moore '63: medicine at the Cambridge Hospital
Alexander L. Nussbaum: biological chemistry
Thomas F. O'Brien '54: medicine at the PBBH
Alfred F. Parisi: medicine at the West Roxbury Veterans Administration Hospital
Mercedes A. Paz: oral biology and pathophysiology (biochemistry)
Liane Reif-Lehrer: ophthalmology
James F. Riordan: biological chemistry at the PBBH
David S. Rosenthal: medicine at the PBBH
Bernard A. Rosner: preventive and social medicine
Robert W. Shapiro: psychiatry at the Massachusetts Mental Health Center
Aziza H. Soliman-Fam: anatomy
Goran K. Svensson: radiation therapy at the JCRT
H. William Taeusch, Jr.: pediatrics
Nicholas L. Tilney: surgery
Robert L. Trelstad '65: pathology
Nancy E. Waxler: sociology in the department of psychiatry at the MMHC
Stephen G. Waxman: neurology

Associate Clinical Professor

C. Lee Birk: psychiatry
Malkah T. Notman: psychiatry
Melvin L. Taymor: obstetrics and gynecology

Senior Research Associate

Nelson Kiang: otolaryngology (physiology)

Assistant Professor

Abul K. Abbas: pathology
Steven L. Ablon: psychiatry at the CH
Nathaniel M. Alpert: radiology at the MGH
Syed M. Amir: medicine
Joseph Askenazi: medicine at the WRVAH
Kenneth A. Ault '70: medicine
Richard E. Belsey: medicine at the Harvard Community Health Plan
Spencer Borden, IV '68: radiology at the MGH
Richard D. Brodie: psychology in the department of psychiatry at the BIH
Steven J. Burakoff: pathology
William J. H. Caldicott: radiology at the CHMC
Martin C. Carey: medicine
Alfred M. Cohen: surgery at the MGH
Harvey J. Cohen: pediatrics
A. Benedict Cosimi: surgery at the MGH
Robert M. Crowell '66: surgery
Philip D. Darney: obstetrics and gynecology at the Boston Hospital for Women
William D. Denckla '65: medicine
Macdonald Dick II: pediatrics
Patricia K. Donahoe: surgery at the MGH
Elizabeth C. Dooling: neurology at the MGH
Jeffrey M. Drazen '72: medicine
Michael G. Ehrlich: orthopedic surgery at the MGH
A. John Erdmann III '67: surgery at the MGH
Kenneth H. Falchuk '66: medicine
Neil T. Feldman: medicine at the PBBH
Raymond B. Flannery, Jr.: psychology in the department of psychiatry
Keigi Fujiwara: anatomy
Ronald N. Germain: pathology
Mark Hallett '69: neurology at the PBBH
Howard R. Horn: medicine at the PBBH
Joseph A. Ingelfinger: clinical pharmacology
Julie R. Ingelfinger: pediatrics at the CHMC

Elsie E. Johnson: anesthesia
Dennis L. Kasper: medicine
Ronald D. Larsen: radiation therapy at the JCRT
Stanley Lee-Son: anesthesia at the PBBH
Michel R. Mandel: psychiatry at the MGH
Eugene J. Mark '66: pathology at the MGH
Thomas G. McNabb: anesthesia at the BIH
Matthew F. Mescher: pathology
Marek-Marsel Mesulam '72: neurology
Stephen W. Miller: radiology at the MGH
John B. Mulliken: surgery at the PBBH
Joseph B. Nadol, Jr.: otolaryngology at the Massachusetts Eye and Ear Infirmary
Dan Nathanson: operative dentistry at the School of Dental Medicine
Rapin Osathanondh: obstetrics and gynecology at the BHW
Andre J. Ouellette: surgery (biochemistry)
Robert N. Pilon: anesthesia at the PBBH
Gerald M. Pohost: medicine at the MGH
Richard N. Re '69: medicine
Helmut G. Rennke: pathology
John W. Rowe: medicine
Nicholas A. Saunders: medicine
Susan Y. Schmidt: ophthalmology (neuropathology)
Gummuluru V.R.K. Sharma: medicine at the WRVAH
Reynold Spector: medicine at the PBBH
Jeffrey S. Stoff: medicine
Terry B. Strom: medicine
Sandor Szabo: pathology
Ludwik S. Szymanski: psychiatry at the CHMC
Ralph R. Weichselbaum: radiation therapy
Howard L. Weiner: neurology
Ronald M. Weintraub '61: surgery at the BIH
Richard N. Winickoff: medicine at the BIH
William C. Wood '66: surgery at the MGH

Assistant Clinical Professor

Joseph L. Andrews, Jr.: medicine
William A. Binstock: psychiatry
Robert W. Carey '59: medicine
Marvin L. Corman: surgery
Per A. Eldh: radiology
Frederick C. Ewald: orthopedic surgery
Axel Hoffer '61: psychiatry
Gary Jacobson: psychiatry
Sheldon D. Kaufman: medicine
Oliver S. Leland, Jr.: medicine
Isaac Mehrez: surgery
Hubert S. Mickel '62: neurology
Lewis H. Millender: orthopedic surgery
Ashby C. Moncure: surgery
Andrew P. Morrison: psychiatry
Paul R. Reich: medicine
Raymond J. Reilly: obstetrics and gynecology
Robert M. Schlesinger: surgery
William E. Strole, Jr.: medicine
William H. Thomas '61: orthopedic surgery
Irwin E. Thompson: obstetrics and gynecology
Hugh G. Watts '60: orthopedic surgery

Principal Associate

Douglas Porter: medicine (psychology)

Principal Research Associate

Mary B. Clark: medicine (endocrinology)
Noriaki Ikemoto: neuropathology (biochemistry)
Lizzy Kappen: pharmacology
Louis Lippiello: orthopedic surgery (biochemistry)
Bela F. Nagy: neuropathology (biochemistry)
Satyapriya Sarkar: neuropathology (biochemistry)
John C. Seidel: neuropathology (biochemistry)
Frank A. Sreter: neuropathology (biochemistry)
Robert E. Zimmerman: radiology (physics)

APPOINTMENTS

Professor

Robert Coles: psychiatry and medical humanities
Daniel D. Federman '53: medicine
John A. Hargreaves: pediatric dentistry
Arnold S. Relman: medicine

Associate Professor

Herbert B. Hechtman '60: surgery
William H. Hetznecker: psychiatry at the MMHC
Harry W. Strauss: radiology at the MGH

Assistant Professor

David F. Albertini: anatomy
Killimangalan R. Bhaskar: pathology
John P. Caulfield: pathology
Peter F. Davison: ophthalmology (biochemistry)
Martha B. Denckla '62: neurology at the CHMC
Paul J. Edelson: pediatrics
Frank J. Holly: ophthalmology (physiology)
Joanne S. Ingwall: physiology in the department of medicine
Alice Y-C Liu: pharmacology
Maria T. Lopez-Vidriero: pathology
Ronald G. Marcus: obstetrics and gynecology at the BIH
Theresa C. McCloud: radiology at the MGH
Barbara O. Meyrick: pathology
Noritsugu Mukai: ophthalmology (neuropathology)
Charles E. Poletti: surgery
Michael R. Reesal: pathology at the WRVAH
Jerome P. Richie: surgery at the PBBH
Richard W. Smith '66: radiation therapy (immunology) at the MGH
Timothy A. Springer: pathology
William R. Veatch: pharmacology

Assistant Clinical Professor

Arthur L. Lage: veterinary medicine in the department of pathology

Principal Research Associate

Mary Lee Ingbar: preventive and social medicine
Magdalena T. Tosteson: physiology

Class of 1981

Adamson, Nelson L.
Kingstree, S.C. (Howard)

Allan, Susan M.
Renton, Wash. (Seattle)

* Alleyne, Claudia M.
Roosevelt, N.Y. (Radcliffe)

Apodaca, Dale M.
Torrance, Calif. (Univ. of California, Los Angeles)

Bairey, Cathleen N.
Modesto, Calif. (Univ. of Chicago)

* Baker, Richard S.
New York, N.Y. (Stanford)

Besser, Mitchell J.
Princeton, N.J. (Williams)

* Bessman, Edward S.
Baltimore, Md. (Johns Hopkins)

Boorstein, Robert J.
New York, N.Y. (Harvard)

Breitbart, Roger E.
Montvale, N.J. (Haverford)

Bressler, Daniel J.
West Covina, Calif. (Stanford)

Brooks, Betsey A.
Bethesda, Md. (Radcliffe)

Bryan, David J.
Cranston, R.I. (M.I.T.)

Burnweit, Cathy A.
Pearl River, N.Y. (Dartmouth)

Calderon, Jose L.
Brooklyn, N.Y. (State Univ. of New York, Albany)

Chaklai, Alisa
Port Chester, N.Y. (Yale)

Chong, Lawrence P.
Monterey Park, Calif. (Univ. of Southern California)

Clair, Walter K.
Chicago, Ill. (Harvard)

Cochran, Nancy E.
Weston, Mass. (Radcliffe)

Cole, Patricia L.
New London, Conn. (Mt. Holyoke)

Crooks, Gary W.
Los Gatos, Calif. (Stanford)

Culver, Perry J.
Lincoln, Mass. (Harvard)

Daniel, Anna G.
Waccabuc, N.Y. (Sarah Lawrence)

Davis, Bonita G.
White Plains, N.Y. (Howard)

Dempsey, Edward C.
Annapolis, Md. (Harvard)

Denke, Margo A.
Mt. Vernon, Wash. (Univ. of Washington)

DePriest, Charles V.
Bedford, Mass. (Harvard)

* Harvard — M.I.T. Program

Desnoyers, Mark R.
Watchung, N.J. (Dartmouth)

Devinsky, Orrin
South Orange, N.J. (Yale)

Dickson, Raymond D.
Carefree, Ariz. (Brown)

* Doerschuk, Peter C.
Newport Beach, Calif. (M.I.T.)

* Dunham, Jeffrey S.
Glenview, Ill. (M.I.T.)

Durand, Marlene L.
White Plains, N.Y. (Stanford)

Eckmann, Kenneth W.
Riverside, Calif. (Univ. of California, Berkeley)

* Eidelberg, David M.
Forest Hills, N.Y. (Columbia)

Emper, William D.
Wallingford, Penn. (Harvard)

Epstein, Mark D.
Brookline, Mass. (Harvard)

Farhi, Jane-Iris R.
New York, N.Y. (Barnard)

Fisher, Elliott
Cambridge, Mass. (Harvard)

* Fong, Chin-To
Yumati, Kowloon, Hong Kong (M.I.T.)

Friedan, Emily S.
New York, N.Y. (Radcliffe)

Furaha, Kuelewa
New York, N.Y. (Univ. of Wisconsin)

Gaensler, Karin M.
Newton, Mass. (Swarthmore)

Gelberg, Lillian
North Hollywood, Calif. (Univ. of California, Los Angeles)

Gerhard, H. John
Ramsey, N.J. (U.S. Naval Academy)

Glotzer, Jonathan M.
Newton, Mass. (Univ. of Wisconsin)

Greenwood, Martha M.
Old Lyme, Conn. (Brown)

Greif, William L.
Bethesda, Md. (Haverford)

Guttmacher, Alan E.
Harborside, Maine (Harvard)

Guyton, Douglas C.
Jackson, Miss. (Univ. of Mississippi)

* Hahn, Peter F.
Beverly Hills, Calif. (Stanford)

Hamilton, Allan J.
Rockville Center, N.Y. (Ithaca Coll.)

Harrison, Charlotte J.
Jamaica, N.Y. (City Coll. of The City Univ. of New York)

H'Doubler, Peter B.
Springfield, Mo. (Dartmouth)

Hergrueter, Charles A.
Peconic, N.Y. (State Univ. of New York, Stony Brook)

Herrmann, Howard C.
Clarks Summit, Penn. (Harvard)

Ho, Dominic K.
Lexington, Mass. (M.I.T.)

Hoffmann, Stephen A.
New Canaan, Conn. (Princeton)

Holmes, Michelle D.
Medford, Mass. (Radcliffe)

Jacobsberg, Lawrence B.
Jamaica, N.Y. (Polytechnic Inst. of Brooklyn)

* Jaffe, Joshua S.
New York, N.Y. (Harvard)

Johnson, Michael R.
Detroit, Mich. (Univ. of Michigan)

Jones, Cedrella C.
Charlotte, N.C. (Williams)

Jones, Christopher R.
Rochester, N.Y. (Univ. of Colorado)

Jones, Clara Y.
Detroit, Mich. (Radcliffe)

Jordan, Barry D.
Flushing, N.Y. (Univ. of Pennsylvania)

Kapnick, S. Jason
Providence, R.I. (Brown)

* Kelsick, Cavelle M.
St. Ann's, Trinidad, West Indies (Radcliffe)

Kochweser, Suzanne
Wellesley, Mass. (Radcliffe)

Kogan, Richard
Hillside, N.J. (Harvard)

Koltun, Walter A.
Toronto, Ontario, Canada (M.I.T.)

Koo, John Y.
San Francisco, Calif. (Univ. of California, Berkeley)

Kuhlman, Janet E.
Erie, Penn. (Radcliffe)

Kvien, William K.
Rockford, Ill. (Univ. of Illinois)

Leefmans, Eric A.
North Miami Beach, Fla. (Wesleyan)

Leon, Jesus M.
Corcoran, Calif. (Stanford)

Lewis, Harry G.
Washington, D.C. (Univ. of Pennsylvania)

* Lieberman, Judy
Cranford, N.J. (Radcliffe)

* Lin, Henry J.
El Cerrito, Calif. (Univ. of California, Berkeley)

* Ling, Alexander, Jr.
Rocky River, Ohio (M.I.T.)

* Lisak, James C.
New Bedford, Mass. (Johns Hopkins)

Liu, Margaret A.
Durango, Colo. (Colorado Coll.)

Lowenhaupt, Manuel T.
Cincinnati, Ohio (M.I.T.)

Lucero, Roxeanne
Las Cruces, N.M. (New Mexico State Univ.)

Macchiarulo, Angela M.
Long Island City, N.Y. (Vassar)

Magaña, Ignacio A.
McAllen, Texas (Texas A & M Univ.)

Marron, Pamela A.
Billings, Mont. (Columbia)

Matar, David J.
Yemin Moshe, Jerusalem, Israel (Columbia)

* Mazzei, William J.
Hicksville, N.Y. (M.I.T.)

McCallie, David P.
Chattanooga, Tenn. (Duke)

Melick Judith E.
Mount Laurel, N.J. (Douglass College)

Mengel, Mark B.
Edmond, Okla. (U.S. Military Academy)

Merz, Robert H.
Weston, Mass. (Vassar)

Michelson, Alan M.
Saint John, New Brunswick, Canada (Dalhousie Univ.)

Morelli, Joseph G.
Jerome, Penn. (Univ. of Pennsylvania)

Morris, Deborah G.
Aurora, Colo. (Tulane)

Moskwa, Alexander, Jr.
New York, N.Y. (Yale)

Myers, David W.
Leonardtown, Md. (Harvard)

Offit, Kenneth
New York, N.Y. (Princeton)

Orentlicher, David
Atlanta, Ga. (Brandeis)

* Pacella, Bernard L., Jr.
Riverdale, N.Y. (Yale)

Parra, Ernesto O.
Los Angeles, Calif. (Univ. of Southern California)

Pastan, Stephen O.
Potomac, Md. (Amherst)

* Payne, Michael C.
Chicago, Ill. (Harvard)

Peebles, Douglas C.
Weston, Mass. (Hampshire College)

Peña, Heather M.
Geneva, N.Y. (Tufts)

Perera, Philip D.
Jamaica, N.Y. (State Univ. of New York, Old Westbury)

Perkins, Isaac
Greenwood, Miss. (Tougaloo)

Phan, Tuyet-Mai
Pacific Palisades, Calif. (Stanford)

Phillips, Minta E.
Ballwin, Mo. (Yale)

* Pincus, David F.
Beverly Hills, Calif. (California Inst. of Technology)

Portis, Jonathan M.
Berkeley, Calif. (California Inst. of Technology)

Preziosi, Andrew J.
Medford, Mass. (Harvard)

Pride, Janice B.
Brooklyn, N.Y. (Barnard)

Pritchard, Timothy J.
Cleveland Heights, Ohio (Williams)

Regier, Janet F.
Cambridge, Mass. (Univ. of Kansas)

Reilly, John J.
Atlanta, Ga. (Dartmouth)

* Relman, David A.
Lincoln, Mass. (M.I.T.)

Reuben, Nancy E.
Rosalyn Heights, N.Y. (Hofstra)

Rimm, Ilonna J.
Watertown, Wisc. (Univ. of Wisconsin, Madison)

Rios, Lydia E.
Bronx, N.Y. (Herbert H. Lehman Coll. of The City Univ. of New York)

Rogers, David B.
Oxnard, Calif. (Stanford)

Rosenkrantz, Karen R.
Cincinnati, Ohio (Radcliffe)

Rosenthal, Carla W.
Baltimore, Md. (Brown)

Rothschild, Richard B.
Encino, Calif. (Univ. of California, San Diego)

Sackstein, Robert
Miami, Fla. (Harvard)

* Samuelson, John C.
Belmont, Mass. (Swarthmore)

Santos, Rene E.
San Jose, Calif. (Univ. of California, Berkeley)

* Scally, Michael C.
New Port Richey, Fla. (M.I.T.)

Schick, Robert M.
Dix Hills, N.Y. (Harvard)

Schulz, Marilyn J.
Monmouth Junction, N.J. (Wellesley)

Schwartz, Carl R. E.
Little Neck, N.Y. (Harvard)

Selwyn, Peter A.
New York, N.Y. (Swarthmore)

Sherer, Rex A.
Birmingham, Ala. (Birmingham-Southern Coll.)

* Slater, Cecelia A.
Spring Lake, N.J. (Princeton)

Smith, Michael D.
Washington, D.C. (Morehouse)

St. Louis, Michael E.
Groton, Conn. (Harvard)

Stone, Richard M.
Swampscott, Mass. (Harvard)

Stradtman, Earl W.
Columbia, S.C. (Washington and Lee)

* Susman, Pia L.
Teaneck, N.J. (City Coll. of The City Univ. of New York)

Swearingen, Brooke
Cincinnati, Ohio (Brown)

Sze, Gordon K.
New York, N.Y. (Harvard)

Tarraza, Hector M.
Puerto Nuevo, P.R. (Harvard)

Tawa, Nicholas E.
Brighton, Mass. (Univ. of Massachusetts, Boston)

* Taylor, Pamela A.
Westboro, Mass. (Mt. Holyoke)

Tepper, Robert I.
Dix Hills, N.Y. (Princeton)

Thomas, James D.
Oklahoma City, Okla. (Harvard)

Thomas, Matthew A.
Salt Lake City, Utah (Harvard)

Torchiana, David F.
Evanston, Ill. (Yale)

Towne, Laurie L.
Goleta, Calif. (Radcliffe)

Traver, James A.
Dewitt, N.Y. (Harvard)

* Vuckovic, Alexander
South Bend, Ind. (Univ. of Notre Dame)

Waitzkin, Ellen D.
Brookline, Mass. (Radcliffe)

Waldman, Linda A.
Westport, Conn. (Yale)

Wang, Janice M.
Lincoln, Mass. (Tufts)

Warren, Ralph L.
Short Hills, N.J. (Harvard)

Watlington, Leigh E.
Philadelphia, Penn. (M.I.T.)

Woolf, Allen R.
Phoenix, Ariz. (Pomona)

Wu, David
Westminster, Calif. (Stanford)

Young, Clarence L., 3d
Baltimore, Md. (Williams)

Young, Diane C.
Hillsborough, Calif. (Radcliffe)

Young, Janet E.
Wilmington, Del. (Swarthmore)

Zarin, Deborah A.
New York, N.Y. (Stanford)

* Zelenetz, Andrew D.
Valley Stream, N.Y. (Harvard)

Zuttah, Silas H.
Have, V. R., Ghana (Yale)

Zylke, Jody W.
Glenview, Ill. (Lawrence Univ.)

Class Day 1977

The Class of 1977 attracted a crowd of fifteen hundred for June 2's Class Day activities — one of the largest turnouts in HMS history. The graduating class numbered 172, including 46 women. After the six student speakers — who among them dealt with most of the medical issues of the day — the special awards, prizes and honors were announced by Alvin F. Poussaint, M.D., associate dean of students. Before doing so, he acknowledged the special heritage of this year's graduates. "The Class of '77 is the last Ebert class, the last class in the old curriculum." About Dr. Ebert, Dr. Poussaint further remarked, "He was willing to take risks, and move in the direction society demands."

Dr. Poussaint

Introducing the day's speakers was Julia Hardy, Class Day Representative

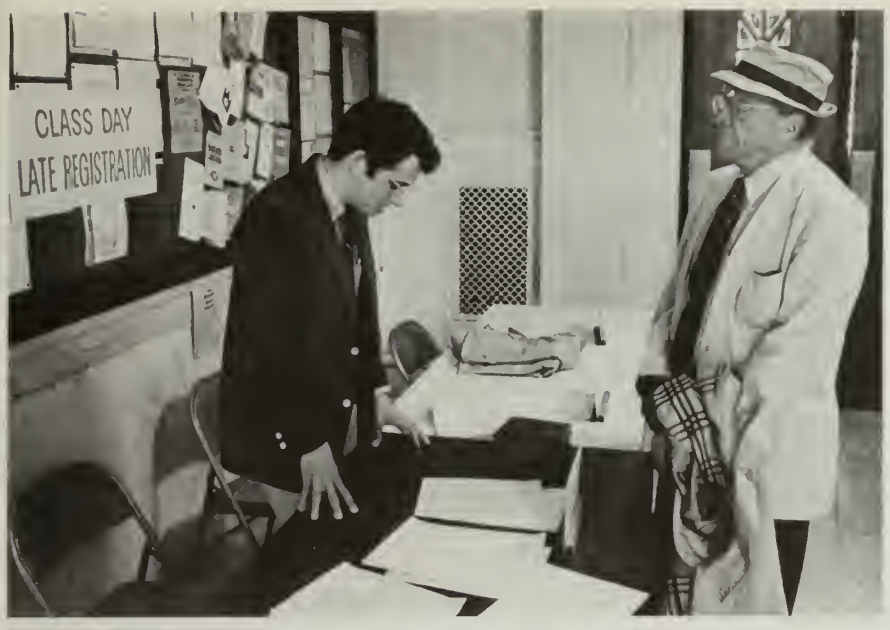
Robert L. Barbieri was the winner of the Harold Lamport Biomedical Research Prize to the "student in the fourth year class who has demonstrated excellence and accomplishment in biomedical research entirely during the period when the candidate was a regularly matriculated student at Harvard Medical School" — as well as the M.D. degree *magna cum laude* in a special field — for his thesis, "The Pharmacology of Danazol." Dr. Barbieri was also one of this year's two recipients of the Soma Weiss Award for medical research, presented May 10 at the annual meeting of the Undergraduate Assembly of the Harvard Medical Society, for his paper "Danazol Inhibits Steroidogenesis."

Dennis W. Choi, graduating in the Health Sciences and Technology Program, was the co-winner of the Soma Weiss Award for his paper "The Effect of Chlordiazepoxide upon GABA Chemosensitivity and Synaptic Activity in Spinal Tissue Culture."

Donald E. Ganem received the Leon Resnick Memorial Prize for the "fourth year student who has shown excellence and accomplishment in research conducted during his period of study at the Harvard Medical School" — and the M.D. degree *magna cum laude* in a special field — for his thesis "Reiteration Mutants of Simian Virus 40: Isolation, Characterization, and Use as Vectors for the Propagation of Foreign DNA in Eukaryotic Cells."

Paul M. Sondel was awarded the Henry Asbury Christian Award "to the student in the fourth year class who has displayed diligence and notable scholarship in his or her studies or research and offers promise for the future" — and the M.D. *magna cum laude* in a special field — for his thesis "Cell Mediated Cytotoxicity in Man: Destruction of MHC Identical Leukemia Cells."

Thomas C. Wright, Jr. won the James Tolbert Shipley Prize for "research carried out by a medical student, the results of which have been published or accepted for publication" — as well as the M.D. *cum laude* in a special field — for his thesis "Spontaneous Aggregation in Transformed and Normal Cells."



In appreciation for his work with students during the past decade, Laura Tosi presented retiring Associate Dean of Students Hermann Lisco with a Canadian Eskimo sculpture on behalf of the Class of 1977. Dr. Lisco remains at HMS to continue his research; he has also assumed new responsibilities in advising graduate students in the division of medical sciences.

Julia Hardy expressed the class's gratitude and affection to Registrar Noreen Koller with the words, "She alone in Building A knows each one of us personally." Miss Koller, an aficionado of sailing, was given a lithograph, Approaching the Horn, *by Carl G. Evers, depicting Sir Francis Chicester's* Gypsy Moth IV.

What the program billed as a "musical interlude" was really a mini-concert worthy of a less restless audience. Beethoven's String Trio in D Major was performed by two members of the Class of 1977, Yeou-Cheng Ma (violin), and Peter Thurlow (cello), joined by Jon Braun '79 (viola).

Along with Drs. Barbieri, Ganem and Sondel, one more member of the class received his degree *magna cum laude* in a special field:

R. Ted Steinbock, for his book, *Paleopathological Diagnosis and Interpretation (Bone Diseases in Ancient Human Populations).*

Seven graduates, in addition to Dr. Wright, were awarded their degrees *cum laude* in a special field:

David E. Burstein, for his thesis "Evidence for Transcriptional Effects of Nerve Growth Factor in the Nerve Growth Factor-Mediated Differentiation in Rat Pheochromocytoma Cells,"

Harold Bursztajn, for his thesis "Design for a Clinical Problem Solving Curriculum in Primary Care: A Theoretical Frame of Reference,"

Chester H. Conrad, for his thesis "Myocardial Ischemia — Electrophysiological Observations,"

Stanton L. Gerson, for his thesis "The Effects of Prior Cytoxic Therapy on Granulopoiesis,"

Ilan R. Kirsch, for his thesis "Antigen Processing my Macrophages: The nature of the immunogenic complex and its relevance to a model for the regulation of the secondary immune response,"

John C. Merriam, for his thesis "The Host Response to Skin Allografts in the Rat," and

Phillip R. Pittman, for his thesis "Immunological Investigations of the Structure and Function of Ribosomal Double Helical RNA."

Alpha Omega Alpha, the National Medical Honor Society, gained twenty-eight new members from among the graduating class: Robyn L. Birdwell, Lynne C. Bookhout. Judith E. Brill, Michael A. Cardi, Ruth J. Crane, Donald E. Ganem, Leslie M. Greenberg, Richard S. Grossman, Allan P-V. Hagen, Robert M. Hartley, Ilan R. Kirsch, Douglas D. Koch, Jedd F. Levine, Frank R. Lonergan, Eric K. Louie, Stephen K. Lucas, Bruce J. McAuley, Robert S. Michaels, Richard A. Miller, Laurie W. Raymond, Daniel S. Rich, Douglas S. Ross, John M. Siliski, Paul M. Sondel, Roger F. Steinert, David M. Steinhaus, Elliot J. Sussman, and Stephen D. Thompson.

A farewell to HMS

by Robert H. Ebert

This is truly a valedictory address, for in a few weeks I shall be leaving the Dean's Office and in six months I will leave Harvard.* So we are both saying farewell. Each of you has concluded an important phase of your life, and I am concluding an important phase of mine. Each of us has learned something while at the Harvard Medical School, each of us has some criticisms of the institution and each of us has some thoughts about what has happened to medicine and to the Medical School during our tenure here. Let me tell you some of my impressions.

I suspect that many of you and possibly most of you would say that there has been relatively little change during your four years at HMS, for you have not been here during a period of transition. But viewed from my perspective of twelve years, there have been rather striking changes. Let me comment on some that particularly affect you.

• There has been a change in the public's attitude toward medical science, and this has resulted in what is perceived by medical scientists as a reduction in the funding for research. In actual fact, the level of funding has increased since the mid-1960s but the rate of annual increase is markedly reduced. The reasons for this are complex, and I do not intend to discuss them here, but I would like to comment on one side effect of reduced funding which most certainly has affected you. There are fewer training grants for those who wish to pursue scientific careers, and academic medicine appears far less attractive to medical school graduates today than it did a decade ago. Some of you have actively participated in research programs while you were in medical school and will continue with academic careers, whatever public attitudes and federal funding may be. And I urge you to continue your scientific careers, for medicine needs you. But some of you who are undecided will have less opportunity than existed ten years ago, and that is too bad because it is impossible to know how creative you might be as an investigator until you try.

> "Harvard has taken the lead in the recruitment of minorities into medicine and it must not now back away from that enormously important commitment."

In all of this the faculty has not changed its views about the importance of research and the rewards of academic medicine, but an external change has limited your options. Indeed, the Medical School has attempted to reverse the trend by offering an M.D.-Ph.D program and by encouraging students to try their hand at research. Opportunities after graduation will be fewer than in the past, however, for both research training and research careers.

• Not unrelated to changing attitudes toward medical science is the increasing interest in primary care on

* Dr. Ebert stepped down as dean on June 30, but continues as a consultant to Dean Tosteson until the end of 1977.

the part of students here and in other medical schools. The subspecialties of medicine flourished in the recent past, in part because they became integral parts of clinical training programs. These training programs are meant to train research physicians, but many trainees became practicing subspecialists rather than medical investigators. Many of these programs have been discontinued. The Congress, which votes the money, is now anxious to recruit medical school graduates into the primary care specialties, including family medicine, general internal medicine and general pediatrics, and you are responding to this along with your colleagues in other medical schools. There is the mythical notion that graduates from public medical schools such as the University of Massachusetts will go into primary care and that graduates of private medical schools, such as Harvard, all go into the specialties. This is nonsense, of course, for you all do pretty much the same things, and now the popular career choice is primary care.

I can hardly claim that Harvard started this trend, but we are doing something about it and hopefully we will do neither too much nor too little. Parenthetically, there are more resources here for training in primary care than in the majority of medical schools, but they are scattered and therefore inconspicuous. I doubt that there is a single medical student in the graduating class who has visited all of the ambulatory care centers available for primary care training in Harvard-related institutions.

• All medical schools experiment with the curriculum and Harvard is no exception. For the most part these experiments have no lasting significance, but there is one which has and that is the Harvard-MIT Program in Health Sciences and Technology. This program has brought together the resources of two great universities and has provided a unique environment for the education of one hundred medical students. I will not elaborate on the program for you are familiar with it, but I would like to pay special tribute to Dr. Irving London '43A, who has personally guided the educational portion of the program and has made it an outstanding success.

There is a general principle involved in this experiment which is applicable to other medical schools — even those which do not have a neighborly school of engineering. This principle — that there can be more than one curricular track in medical school — may be the most significant contribution made by the program.

• I would like to conclude with what I think is the most significant change of all, both nationally and here at Harvard, and one which may be in jeopardy. When I became Dean in 1965, the Medical School student body was 3 per cent minorities and 7.5 per cent women. Today the percentages are 20 per cent minorities and 31.5 per cent women. Let me tell you first why I think the change has been important. An almost all white, predominantly male student body made for a rather comfortable relationship among students, but it hardly reflected the real world of medicine. Illness does not restrict itself to certain racial groups or by sex, and if one is to practice good medicine, one must know something about the people who are sick. Most educators would agree that medical students learn as much from one another as from the faculty, and an important part of that learning has to do with attitudes towards others. The practice of medicine is more than science and ritual, and the difference between a good physician and a poor one depends as much on how he or she will communicate empathetically with patients as it does on the knowledge and skill with which he or she practices the science and the art. It becomes obvious, then, that a student body which is a mix of men and women and of majority and minority students provides a better learning environment than one which consists of only one kind of student.

There are some who worry that a student who does not test well and has had difficulty with one or another of the standard examinations taken by medical students will, as a direct result, be a poor physician and will endanger the lives of his or her patients. The same critics worry not at all that a student who tests well may be totally unable to communicate with a patient of another race or socioeconomic group and therefore may be quite incapable of obtaining an accurate history. No one seems to worry that this failure may truly endanger the patient.

Harvard has taken the lead in the recruitment of minorities into medicine and it must not now back away from that enormously important commitment. There is no absolute correlation between the ability to test well and to become a good physician, and it is simplistic to choose among students only on the basis of grades and tests. Medicine is now and will always remain a humane profession and humanity is measured by what one does for others and not by the results of examinations.

Dean Ebert is clearly pleased with the Class of 1977's parting gift, proferred by Ellen Jantzen. The Dean's hobby, fly fishing, inspired the choice of the John Cowan print, Deep Run.

Reflections on teaching and research

by Elio Raviola

When I was invited to speak to this graduating class, I thought that this was my first chance to reflect a moment on that period of my life, now six years, that I have spent in this institution and in this country.

As you can well imagine, the force that dictated my decision to move to Boston at the age of thirty-eight, besides the encouragement of Dr. Don Fawcett, was the desire to find a sound environment in which I could express myself as an investigator. In the lacerating moment of departing from my people and my homeland, a thought continued to recur in my mind: I was convinced that I would never be able to be an effective teacher in a foreign place nor to enjoy teaching with students of a different blood, background and language.

These feelings blended with all the hesitations of a European immigrant who moves to this country. My favorite Italian writer of the '50s, Cesare Pavese, vividly expressed his reactions to this country: "This is not a place in which one can surrender, recline one's head and tell to people: look, I had bad luck, but you know me, you know my father, you know my family. Just leave me alone."

As I began to work here, I quickly changed my mind. Not because of the scientific community, however, because I had been here before and I knew the members of the anatomy department. In addition, when one has grown in an environment removed from the mainstream of scientific communication, one learns to distill from scientific articles the true mind of their authors and one soon becomes acquainted with their personalities as though they were one's nearest kin. The major source of surprise was the students of this school, and I must say that interacting with you has been the most remarkable experience of my recent past. A common feeling among investigators who trade their homeland for the chance of expressing their intellect is a sense of emotional insecurity, of loss of ethnic identity, as though one does not belong any more to a well defined human community, except — perhaps — to the loose international consortium of the ambulatory scientists, a modern version of the knights errant of the good old times. In addition, the life of a basic scientist is continuously geared to the future and, at times, one feels segregated from today's living society.

Besides being selected as Class Day speaker by the Class of 1977, Dr. Raviola was singled out by members of the Class of 1980 in a different sort of ceremony on May 25. As Dr. Raviola brought the semester's gross anatomy course to a close, Amphitheater C suddenly became the scene of an event similar to one that most of us watch on television once a year. Elegantly attired young men took over the podium as masters of ceremonies, and gowned and gloved ladies escorted nominees to center stage as winners were announced in the categories of Best Supporting Accent, Best Slide Collection, Best in the Special Effects Category, and Best Anatomy Professor. The occasion was, of course, the Anatomy Awards.

Along with his Oscar for Best Anatomy Professor (a nude Ken doll embellished with anatomical drawings), Dr. Raviola was presented with a portrait of himself painted by David Low '80. He is depicted in the classic anatomist's pose — erect, full face, right hand on skull — but instead of the equally classic austerity of expression is Dr. Raviola's typically warm, smiling, eminently approachable countenance.

All these clouds were dispelled from my mind the very first day I began to teach here. I felt at home, in my country and among my true people. Every spring, as I go through the ritual of the gross anatomy course, you give me an extraordinary feeling of being an integral part of the fabric of the living society and for this I am very grateful to you.

I must admit that the situation of a foreign physician who concentrates on basic science and likes teaching has its disadvantages: paraphrasing one of Dr. Folkman's favorite jokes, your clinical colleagues ignore you, perhaps because you did not take the National Boards. Your basic science colleagues regard your teaching skills with amusement and a shade of commiseration, as though you are exhibiting in public, without shame, some sort of congenital deformity. And the students keep asking you with genuine astonishment "What are you doing the rest of the year?" As though, with your pockets filled with mothballs, you spend your winter in a closet, hibernating before the next course of anatomy.

These, however, are irrelevant aspects of a teacher's life, when compared to the intimate joy of sharing one's knowledge with an inquisitive young mind and the privilege of continuously remodeling one's vision of the world under the influence of newer and newer student generations.

The vigorous attack by Patricia Glowa on certain choices made in the anatomy course of 1974 made me reflect seriously on the unconscious sex bias in my teaching. The reaction of your class to the patient-physician interaction in the clinics and some unusual episodes, such as the infinite gentleness of Ronnie Heifetz, who played his cello for a patient in the hospital, made me aware that today's young generation has a much more profound perception of human need for respect and affection than my achievement-oriented generation.

This humanitarian concern of young people is a good omen in the moment when man's mastery of technology is threatening to extinguish compassionate feelings among humans; a moment, in which only a profound change of heart may move the present society to abandon its present objectives and lay the foundation for a better way of life.

But there is something else I have found in this quadrangle: an aspect that most of you take for granted and do not fully appreciate as much as I do in my everyday life. These buildings, with all their imperfections, represent one of the few remaining islands of academic freedom, in which nobody, overtly or surreptitiously, denies your right of expressing your opinion and of freely confronting your views with those of your tutors. Although society is beginning to impose some restrictions — now there are policemen at the doors, visitors must wear a tag like rare trees in an arboretum, and more and more postdocs are yoked to the wagon of NIH research grants — although the very essence of the concept of freedom has become a matter of debate, this is still a good place to live in and scream out your dissatisfaction. I hope that this healthy attitude you have expressed in your formative years will survive the hardships of the residency and medical practice and accompany you throughout the rest of your life.

"Today's young generation
has a much more profound perception
of human need for respect and affection
than my achievement-oriented generation."

I have been told that a speech at graduation day should contain a message that the audience can carry with them in their future profession. It is beyond my expertise to comment upon the medical system in this country: I am barely beginning to become acquainted with its complexities. Nor am I best suited to discuss the essence of the medical profession or the problems of patient-physician interaction. After all, I have chosen a basic science career instead of continuing in medical practice. Furthermore, I have known you well enough to predict that you will be good doctors and compassionate doctors.

I would rather touch on an aspect of your training in this school that is a source of continuous criticism from part of the student body: two years ago a student said on graduation day that at Harvard Medical School one must become a practicing clinician in spite and not because of the system, which is primarily research oriented. Let me express my opinion as a European who not long ago was an outsider. Today, this is the only country in the world which has the will, resources and manpower to carry on advanced biomedical research; although generally unrecognized abroad, this is one of the major contributions of the United States to the welfare of mankind.

In research — and this is especially true in clinical research — the concerted efforts of individuals must reach a critical mass to be productive. Large institutions such as Harvard Medical School provide that spiderweb of intellectual exchanges and the diversified environment in which can flourish that peculiar form and biological experimentation that is called clinical research. With its strengths and weaknesses, Harvard Medical School subserves an indispensable service to modern medicine and to the international community.

A member of this graduating class, Vincenzo Falanga, a countryman of mine, asked me at the beginning of his first year of medical school whether there was any real advantage in being at Harvard as compared to his home medical school in Naples. Of course, was quite biased in my answer, considering my personal history; but there is little doubt that all of you have had the unique opportunity to appreciate what clinical research is about. Thus, my wish is that many of you, most of you will become biomedical scientists. You have intelligence, imagination and good training. The goal is exalting: with a bit of luck and a lot of perseverance, in-

stead of curing thousands, perhaps tens of thousands of patients in your lifetime, you may be of help to all generations to come.

Whether scientific progress is going to continue or slow down does not depend on the powers of the human mind, which still seem limitless. The progress of medical science depends on a variety of factors: the attitude of society toward scientific achievement, the benefits that return to the society from scientific achievement, and whether individuals of the highest intellectual ability continue to be interested in science. Your decision, in a sense, is an easy one: nobody believes any more in the neutrality of science, since good and evil are balanced in most scientific discoveries. In the health sciences, however, the odds are strongly in favor of humanity.

Of course, in the context of clinical investigation, you will face the problem of experimenting on the patient. Nobody can help you in this difficult decision, but I am confident that your conscience and your heart will always dictate to you the right answer.

I have insisted on the aspects of the personality of this class that most struck me when I was trying to teach you human anatomy in five weeks: your intelligence, your perceptive criticism, but especially your keen sense of human rights. It appears that your generation has a better grasp of the psychological and social components of disease and thus is better prepared to translate them into rigorous scientific parameters.

I have the feeling that we are on the verge of dark ages for our society. The human species is subverting the laws of evolution and by reckless exploitation of the natural resources is rushing toward its own destruction. The task for the generations to come is difficult: on the one hand, they have to continue to expand the frontiers of knowledge in search of a better balance between humans and their environment. At the same time, they have to generate a new set of moral values in the relationships among human beings. As health professionals you are at the very center of this dilemma, and you cannot evade the responsibilities you assumed on the day you chose to enter this medical school.

Diet, disease and disbelief: the consensus factor

by Mark A. Levine

One day my medical resident told me what he thought was a funny story. A seventy-four year old clinic patient was constantly bothered by weakness and malaise, without any clear cause. On one routine visit the man said he had found a cure — a B complex vitamin tablet with ascorbic acid. My resident snickered, and so did the other residents who were listening. The snicker is what is most interesting to me in the story. It is based on a consensus of opinion among physicians: once our patients are eating a so-called normal balanced diet with low cholesterol and unsaturated fats, then the diet has no influence on the development of disease.

Consensus is not a new phenomenon in medicine. In 1865, Joseph Lister read of Pasteur's experiments that proved microbes caused meat to decay. Lister reasoned that the same process might occur in wounds. Using carbolic acid, he discovered that wound infection and gangrene could be prevented. In 1867 he wrote about his success in a prestigious British journal and in the next two years the surgical death rate of one in three from amputation was sent plummeting by his aseptic technique on the Glasgow and Edinbugh wards. Yet final acceptance by the leaders of the British medical community did not come until 1879, and then only after a fierce fight. Ignatz Semmelweiss, who had tried to popularize asepsis earlier in Europe, was not so fortunate. The laughter at his work and the preventable deaths drove him to insanity before his early death.

Historically we physicians are slow to accept a new idea. And once ingrained, the idea takes even longer to dislodge. Christian Eijkman found in 1890 that a disease mimicking beri-beri almost invariably could be produced in fowls by feeding them white rice. When unhusked rice was used, or when husks were added to the white rice, the birds recovered. The results were independent of the source of the rice. Eijkman received the Nobel prize in 1924 for his

Mark A. Levine is an intern in medicine at Johns Hopkins Hospital.

To opt for a cure

by Woodrow A. Myers, Jr.

work in vitamin deficiency disease. Yet eight years after his original discovery, Eijkman still declared that infection was the most likely cause of the disease. The microbes which twenty years before were not believed to cause any disease were now thought responsible for nearly every illness.

What does all this have to do with diet? Of many examples, Vitamin E provides a rollercoaster story of resistance to new information. This vitamin has been promoted for treatment of everything from sterility to air pollution, and its very mention can provoke those familiar snickers. Yet in double blind studies, calf pain upon walking, or intermittent claudication, has been relieved by Vitamin E. And if one looks objectively at the data, the issue of relief from angina with Vitamin E has never been settled. Most physicians continue to treat patients with intermittent claudication traditionally, as consensus laughs at vitamin therapy. At stake, however, is a greater issue, which might concern that elderly clinic patient. At present, our understanding of what is an adequate vitamin intake is very crude at best. We have no way of estimating the maximum requirement of vitamins under varying stresses. The idea of an excess of vitamins is hard to assess because it may be relative to a particular metabolic state. So even the adequacy of the recommended daily allowance for maintaining good health comes into question. Indeed, that clinic patient may had had the last laugh.

We are about to become part of the group that determines what the consensus of opinion is. We are young in medicine and impressionable. There will be new data, and there is plenty of old suggestive information, on the relationship between diet and disease. I hope that we will not snicker at patients whose calf pain is prevented by Vitamin E, or whose tumors regress with ascorbic acid. Please — let's look at the information objectively, without unfounded resistance and without the snickers of consensus.

For too long we have attempted to palliate known malignancies harbored within the health care system. Neither denial, subterfuge, nor an erratic infusion of imported personnel has done more than temporarily alleviate the symptoms of our critical health manpower shortage. Hundreds of politicians, government bureaucrats, and Ph.D. candidates have made their living discussing, describing, analyzing and approaching the problem.

This shortage does not exist in or affect Newton, Scarsdale or Sausalito, but it is indeed a reality for Benton Township, Missouri; Chula, Mississippi; and Dell City, Texas, not to mention many medically underserved areas within this nation's inner cities. For many patients the problem is not merely one of proximity. There is a growing breed of physicians who are refusing to care for the medically indigent, not only because of delays in receiving Medicaid payments, but also because the level of reimbursement is much less than a middle class clientele will agree to pay.

Historically, organized medicine has responded by denying the existence of a shortage, and by actively fighting meaningful efforts to increase the supply of physicians. A few journalists have ex-

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Woodrow A. Myers, Jr. is an intern in medicine at Stanford University.

trapolated from this denial the spectre of a surplus of physicians. With these warnings come predictions of mammoth increases in health care expenditures secondary to the oversupply. Many facts effectively counter this position. Over 6.2 million people live in federally designated medically underserved areas. In response to this situation, Congress established the National Health Service Corps via the Emergency Health Personnel Act of 1970. With this Act the federal government entered the business of supplying physicians for areas where a critical health manpower shortage exists. Despite the large increase in government employed physicians, many towns continue to advertise for, and many individuals continue to plead for access to a local physician.

Propelled by federal funds, American medical schools have responded reluctantly with a modest increase in the number of graduates, a number not sufficient to meet the present need. Organized medicine, in collusion with Congress and the State Department, has encouraged the immigration of foreign medical graduates into the United States.

In the past decade the percentage of foreign medical graduates in the United States has doubled. Today, one in five practicing physicians in America is an FMG. Over 15,000, or one third, of this country's interns and residents are foreign trained, predominantly in India and the Philippines. The citizens of these nations can sorely afford to lose this talent. While holding almost thirty per cent of filled housestaff positions in affiliated teaching hospitals, these physicians hold sixty per cent of those positions in non-affiliated hospitals. Many of these hospitals are the sole health care resource for the urban poor. After residency a disproportionate number of FMG's locate in urban inner city areas, and care for America's medically indigent population. While Congress approved legislation last year that would limit the number of incoming FMG's, special interest groups, the Department of Health, Education and Welfare and the State Department have delayed for a year, and will perhaps delay indefinitely implementation of the law, and America's dependency on FMG's will continue.

It continues despite the fact that well over half the applicants to American medical schools are not allowed to enter the profession. Unfortunately the frustrated and rejected have irrationally focused their outrage on the nine per cent of American medical students who happen to be members of minority groups. While one of every five physicians is a man or a woman imported by this country to care for its non-suburban population, less than one in fifty practicing physicians is a black American.

Initial steps have been taken by this country to improve access to quality medical care. With a valid Medicaid card a patient may quite easily walk into the Peter Bent Brigham Hospital and receive excellent medical care, unencumbered by poverty or unemployment. It is not that easy for millions of other Americans.

As our generation of physicians fits into the health manpower equation we must demand quality medical care for all individuals regardless of their assigned value in a cost-benefit analysis, or a cost-effectiveness equation. To accomplish this goal, organized medicine's artificial ceiling on the annual number of physicians to be produced must end. The profession must admit more of us who are dedicated to excellence, and who know by experience the problems of being poor, of being black, and of being medically underserved. And if a hundred years from now there is an oversupply of physicians, then it will be this country that will export talent to nations where it is needed. We must reorganize organized medicine, we must take an active interest in government, and we must never compromise human rights.

Treating the symptoms must stop. It is time to opt for a cure.

Women and medicine

by Patricia T. Glowa

Four years ago when our class came here, I was pleasantly surprised that one quarter of our number were women. However, it soon became evident to many of us that an overwhelmingly male attitude permeated the institution. We reacted in a variety of ways — some of us became active in women's groups, others tried to adapt and simply work harder. Many things have changed over four years and we now have a professional role to contend with.

Women entering medical school now are more independent and confident of their own worth. In part, this is a reflection of the prominence of the women's movement in the last decade and is to be applauded. Women less often feel the necessity to justify our natural ambitions to ourselves or to the world. Joining a women's group, however, involves acknowledging to ourselves that we may not be powerful enough to affect our environment alone. If we do not seek support from other women, then we must seek our approval from the men in our classes and the men who teach us, who may not always understand or appreciate our differences. We may find ourselves unconsciously conforming to their behavior patterns to gain their friendship and support. At that point we have lost a valuable part of our independence.

Patricia T. Glowa is an intern in family practice at Highland Hospital in Rochester, New York.

Although we claim equality, we do not claim or desire sameness. Women are usually brought up to be highly sensitive to other people's needs and feelings, to listen, support, and give. We can bring an invaluable expertise to medicine if we allow ourselves to acknowledge these abilities and develop them in our work.

Medical school is an intense socialization process in the direction of aggressiveness, extreme independence, assumption of responsibility — all qualities that are to a degree necessary for doctors. These qualities are commonly conceived to be "masculine," and the one-sidedness of our training gives medical school its extremely "masculine" atmosphere. While it is valuable for women to be aggressive — part of the time — it is also crucial for women to retain the caring and listening qualities. It would be a tremendous loss to everyone if women in medical school tried to become more "masculine" than the men themselves. It will be a tremendous advance when medical schools cultivate some of our "feminine" qualities.

One of the crucial issues facing medicine now is the quality of patient care and the changes demanded by patients. Feminists in medicine have advocated changes related to patient care issues. We published a report on sex discrimination at Harvard, documenting some of the myriad instances of discriminatory or uneducated attitudes — mostly examples of "trivia" that grate and grind away at a woman's identity. Patients, too, are demanding to be treated with respect and attention, not to be overlooked, ridiculed or patronized.

The problem of quality of care delivered by housestaff is addressed in the issue of part-time residencies — which, contrary to the name — usually mean thirty-five to sixty hours per week. Those who raised this alternative were initially women who needed more time for their young children, but the group now includes men and women who wish to combine their medical training with other commitments. The quality of care that can be delivered by acutely and chronically exhausted housestaff is compromised. Part-time residents will be better able to meet both their families' and their patients' needs, as well as their own need for a more humane training experience. Development of these programs must lead to a reevaluation of concepts of medical education and a challenge to the time-honored tradition of training by inundation and sleep-deprivation. Housestaff on a more reasonable schedule might be better able to care for the whole patient without the inevitable resentment of one who is allowed so very little time for sleep and relaxation.

In reviewing our four years here, I have been struck by the enormous pressures brought to bear on us to become aggressive and independent in an unbalanced fashion. Many women try to assume these qualities in order to be accepted — that is the nature of humans as social beings. The pitfall lies in the price that can be paid — the price of losing a woman's strengths of caring and listening. Until medical schools have had more time to absorb our qualities into the socialization process, we cannot afford to seek uncritically the approval of the men around us — we have something to teach as well as to learn. Many of the things we are trying to teach affect medicine in a far-reaching way — as examples, the issues of subtle discrimination and of part-time residencies have implications for patient care as well as for the treatment of women in medical school. Above all, it is important for us to remain involved in the process of our own education — to question, to think, and when necessary, to change for the better.

School spirit at Harvard Medical School

by Paul C. Shellito

When I first came to HMS, I expected that at graduation I would look back upon my years as a medical student with nostalgia. Unfortunately, however, I don't get misty-eyed when I think about leaving Harvard Medical School. Not very many of us feel a sentimental affection for HMS today. Furthermore, a few have an outright hatred for the place.

Paul C. Shellito is an intern in surgery at Massachusetts General Hospital.

Of course, we all have had good experiences with scattered individuals at medical school, both faculty and students. But we never treasured our class as a group. Similarly, we didn't seem to love HMS for its history, favorable traditions, and its dominant role in guiding our education and professional maturity.

What we lack is an *esprit de corps*. As a group, we never really committed ourselves to HMS, and to each other. During the last four years we had difficulty getting together on anything. And this attitude is not unique to our class. Second and fourth year shows have often suffered from a lack of participation. The various clubs and societies at the medical school sometimes find it difficult to survive without more student support. The dining hall at Vanderbilt, which is the only place that medical students may gather and eat together, does poorly because so many would rather eat in their dorm rooms or elsewhere, and the administration is reluctant to subsidize it.

School spirit at HMS hasn't always been so poor. In a recent article in the *Alumni Bulletin,** Dr. Charles Huggins '24 emphasized, by contrast, our present apathy. In his "Valentine for HMS," he wrote that during his first year "the students could feel the *esprit de corps* which had been contracted on that Indian Summer day in 1920 — we had fallen in love with medicine and the Longwood Campus." It seems that none of us would write such a valentine today.

The lack of strong medical student fellowship at HMS was further emphasized to me last summer, when I took a rotation at St. Thomas's Hospital Medical School in London. School warmth and enthusiasm was obvious

*Charles B. Huggins, "Surgery 1920-24: A Valentine for HMS," *Harvard Medical Alumni Bulletin,* 51 (1976), 18-21.

there, and it manifested itself at frequent class parties, sports events, and comedy shows, as well as during daily activities such as ward rounds. They were quick to make me feel a part of it, too.

We, the students, are partly responsible for the situation at HMS. Perhaps it is the more competitive, aloof, and suspicious students that are being selected by medical schools today. Competition has always been with us, but maybe it is more malignant now. Our third and fourth year clerkships brought out the worst in some of us.

In addition, we are probably a less homogeneous group than in previous years, with less in common to enjoy. Although increased diversity among the individuals accepted to HMS is a good thing, it is unfortunate and unnecessary that it should compromise student fellowship. Similarly, students perhaps have more concerns outside of medical school that cause us to neglect student life at HMS. We tend to have our own ambitions, or "causes" in mind, often, regrettably, to the exclusion of the student body.

On the other hand, at least half of the responsibility for our situation rests with the faculty. Many of the unfavorable medical student attributes that I have enumerated have been induced by the expectations and attitudes of our teachers and administrators. "Roundsmanship," for example, would not exist if it were not encouraged by our superiors.

There have been plenty of examples, especially when we were first and second year students, of animosity between faculty and students that made it difficult to feel that we would ever get along, much less like one another.

I believe that the lack of *esprit de corps* and nostalgia at Harvard Medical School is a shame and a disaster. It seems that our attitude is typified by the HMS student who recently informed me that the only value of the Medical School was that "it helps your career."

What then will prevent HMS from becoming a sterile, spiritless, and laborious institution that one appreciates only because it furthers one's career? Some of the faculty, particularly the older members, do support student fellowship. Of greater importance, however, are the presently graduating students who will become the supporting alumni and future faculty of the Medical School. We should all try to see what is happening to the lives of HMS students. If we wish this unfortunate trend to reverse itself, and *esprit de corps* to return to the quadrangle, we must recognize the problem and stimulate valentine sentiments about Harvard in the future.

The new Third World physician

by Phillip R. Pittman

The basic problem in the US and Third World communities, besides injustices to minority groups, is the problem of poverty — and gross maldistribution of wealth and power. Thus, it is no surprise that in speaking about health care one must speak about poverty. What is a surprise is that it is acceptable to speak about everything but poverty when we speak of health care. Look at the list of speeches on the Class Day program. Where else is poverty being spoken about? Why is there this silence about poverty?

Following the death of the Reverend Dr. Martin Luther King in 1968, certain institutions of higher education finally recognized their centuries-old blindness and began speaking to the needs of minorities. Some even cracked open their doors to groups cast out for over four hundred years. But that dream, like many, many others, has been shattered by cries of reverse discrimination.

In the early seventies the feminist movement made the notion of women in medicine chic. The focal point of affirmative action for minorities and the poor changed gears. But the needs of our poor communities *as* poor communities — the ghetto, the barrio, the Appalachias, and the delta regions of Mississippi — have not been adequately addressed. The poor still suffer unnecessary health problems simply because they are poor. If communities were the size of cells and if hospitals, laboratories, physicians and patients were the size of subcellular particles, they might receive much more attention and care.

While they have been subjected to research (research which has often been unethical) they have not received much attention and care. Moreover, they will not — for the sort of attention and care that would be required by poor communities would involve an equilibration of wealth. This process will not occur in the near future. However, what can be reinforced here today is the Harvard Medical School's commitment to share its wealth of knowledge by making itself available to those people from poor and minority communities who wish to become physicians. In this manner, the suffering of millions of people can be ameliorated. The motto of "life, liberty and the pursuit of happiness" will become more than just words.

I should like to end with this poem.

To the New Third World People
Keep your face to
the sun
And you cannot
see your shadow
The New Third World People
commands
Don't walk in front of me no more
I will no longer follow
Don't walk behind me
I will no longer turn when
say so
This is a new day
Walk with me
or
you go your way
And I go mine!

Phillip R. Pittman is an intern in medicine at Presbyterian Hospital.

On remembering at midnight what we may have forgotten at Harvard Medical School

by Judith E. Brill

There is a long oral tradition at Harvard Medical School, stories passed on at cafeteria tables or on quiet wards late at night among students, house officers and sometimes even faculty members. Each of us now graduating has a collection of tales on a variety of subjects, ranging from embarrassing moments during our first physical exams, to gruesome scenes witnessed in emergency rooms, to descriptions of "the most interesting" or baffling cases we have seen. I would like to share one of *my* never-to-be-forgotten stories.

During our Examination of the Patient course — our first actual contact with patients — my partner and I held our black bags in hand and followed our surgical instructor on his rounds. We visited a frightened, haggard woman scheduled for surgery the next day. We chit-chatted and joked; we all three felt her belly which had a mass easily appreciated even by us novices. I remember her eyes upon us — terrified, full of questions unasked, unanswered. When we left and were marching down the hall to the next patient, our teacher said, "Well, what did you think, hmmm? Impressive, hmmm?" No one jumped to answer him, since neither of us wanted to be the first to show our ignorance. But it was just as well, because suddenly our surgeon answered his own question. Turning to us he snarled, "*She's a dead duck.*"

This is only one example of the way that one doctor deals with patients who have a distressing or incurable disease, and how he deals with the anger that accompanies treating the ultimately untreatable. But there were many, too many other examples of insensitivity during the four years of medical school — insensitivity to patients, insensitivity to their families, insensitivity to students (for what does a student learn from the diagnosis "dead duck"?). Too often there was too little time to offer the small kindness, the reassurance, the honest answer.

Now, for the first time, we will occupy positions from which we will touch the lives of what will seem like far too many patients. Although no longer officially students we will still really be in the process of becoming. How nice it is still to be malleable! The habits, the style which we acquire will be learned in the next year, and the year after, and in those that follow. So the end of medical school is actually the beginning of a period as important as any other we may have encountered in the past. Consequently the short interval before our internships is a time deserving of introspection and some careful reflection. The likelihood of then recalling some of the sensitive ways of behaving with patients, of adding kindness to carefulness, efficiency and good clinical medicine will be increased.

Internship is trying, tiring, painful, often unbearably demanding. We will all need to remind ourselves at times that there is a person, a patient, who will be the recipient of our bleary-eyed, unheralded, hopefully care-filled ministrations. Midnight, after the umpteenth admission of the evening, is a difficult hour for remembering some altruistic thoughts first worked out long ago, probably before we each even entered the world of medicine. But it is then, when the stresses are greatest, the weariness overwhelming, the responsibilities unending, that we must remain in touch with some understanding of why we are standing on a quiet ward in the middle of the night. The answer must include, in part, a desire to treat people not only with the best medicine available but also as the best physicians we can be. And that physician is one who remembers to be kind, to be gentle, to be sensitive to even the smallest, most subtle needs, to be reassuring, and to see the patient as a whole person.

Then there will be no "dead ducks" because it will be impossible to sum up a patient so easily and shockingly. We are being given so terribly much power — the power to touch the lives of countless people who will be at their most vulnerable when we meet. Before those midnights arrive, before we become the practitioners and teachers we soon will be, let us pause and remember why we are physicians and think how to preserve our sensitivity in the face of new and bigger challenges.

Judith E. Brill is an intern in pediatrics at Children's Hospital Medical Center in Boston.

Letters

A special group

There is a portion of our class which for too long has gone unrecognized and to whom each of us should be thankful. They are what I might describe as the quiet, gentle souls who trod softly, harming no one in the mad scramble for security which has plagued us all. They didn't clothe themselves in the name of Harvard or of medicine; they didn't need to. They brought their own sense of values and identity with them and knew that all too often and all too quickly institutions can fall away, leaving one naked and afraid.

In crises, they gave, they didn't take, and often they were hurt as a result. But what's more important, they didn't stop giving the next time around. It's no wonder they were confused when told in the clinical years. "You aren't aggressive enough," "You spend too much time talking to patients," and "You don't cite journals enough." The game of roundsmanship didn't appeal to them, and not playing it, they were made to feel inadequate. Their concept of medical learning was often at odds with the mainstream for legitimate reasons, but their opinions were often not heard or were misunderstood. Many of these people will not be Harvard interns, and many will suffer from the subtle inference that they have in some way failed the system. But as a class, we all know who helped us laugh, who made us take a second look at Harvard and at the false sense of elitism that it breeds.

You quiet, gentle souls will carry your giving spirit to new places and to more people who need you. We will remember what you gave us and hope that we grow in your example.

Laurie Watson Raymond '77

"Sensitive" . . . or "sententious"?

It was possible to chisel a few brief moments from my otherwise granitic schedule to attend Class Day exercises, and I was enormously impressed by the medical student speakers that I heard. In addition to noticing a keen awareness of some of the difficulties in medical education in general and Harvard Medical School in particular, I remarked on the fearlessness with which they spoke out about their concerns. It left me with an enormously heartened attitude.

The implication I drew from those speeches was that the intensity of human concern, despite all that has been said about the decline of this variable, continues to survive in the class. Many of us who work intensively with medical students find ourselves increasingly concerned that humanitarian considerations may be in the process of being screened out by admissions committees. I found the Class Day speeches enormously reassuring around this point. If these qualities — ethical sensitivity, awareness about issues of human concern, and fearlessness to speak out about these concerns — continue to survive the medical school selection process, then this alumnus, at least, feels that there may be hope for the old place yet.

Thomas G. Gutheil '67

The following letter was written in May, before this year's Class Day. — Ed.

Those of us who grew up in the skeptical decades preceding the middle of the twentieth century always imagined that the First World War had put an end to a peculiar style of discourse which was at once earnest, unctuous, and sententious. This kind of moralizing is forever associated with the era of Queen Victoria but it is difficult for us in the twentieth century to know how her subjects viewed lectures and essays in this style. We do not know whether Victorians thought them convincing or thought them to be humbug. In any case, when we read these sorts of sermons eighty or ninety years later they simply set our teeth on edge.

It seems, however, that burial was premature. After having read, as a penance, all the commencement addresses and letters to the editor by recent graduates and students of the Harvard Medical School printed in the *Harvard Medical Alumni Bulletin* in the past few years, I now realize that even the most canting Victorian clergyman might find himself bested in the areas of self-righteousness and priggishness by certain of our modern students. The great Queen would surely recognize the style, although doubtless she would be appalled by the subject matter of some of these current hortatory addresses. Many of the ideas put forward are good and sound but perhaps a leavening of humor, perspective, and irony would make the assertions more persuasive. I suspect that a number of listeners and readers really are put off by the pretentious formulations and the scarcely disguised rage.

Ransom J. Arthur '51

The quality of family practice residencies

I was appalled to read Dr. Prout's comment in the May/June issue that "The number of students applying to family practice internships dropped sharply from last year, but on talking with them it is quite evident that this is because students perceive these internships as being inferior in quality to those in internal medicine." If students perceive this to be true, it is because Dr. Prout and others tell them that it is true and because there have been no family practice role models available at Harvard.

As a family practice intern at Worcester City Hospital I am delighted to be working at last in a cooperative environment with people whose primary goal is learning to respond more adeptly to the physical and emotional needs of their patients. I invite any student who is disenchanted with the Harvard academic approach to medicine and who is considering family practice as an alternative to contact me for further discussion.

Rachel Wheeler '77
Family Health and Social Service Center

To rank or not to rank

The May/June 1977 issue, focusing on the internship recommendation procedure, raises some issues which are worthy of comment.

For the past several years I have simultaneously participated in the internship selection procedure and the letter writing procedure for fourth year students at the New York Hospital-Cornell University Medical College. I agree with those respondents who, in Deborah Miller's article, felt that Harvard's evaluation letters range from confusing to incomprehensible, and I disagree, on the basis of students I have seen, with Dr. Gardell's assumption that "two-thirds to three-thirds of Harvard students are in the top third." (I am not speaking about our Harvard Medical School housestaff, who are excellent.)

It is interesting for me to compare my estimates of the recommendation letters of Harvard students whom I have interviewed with their final internship positions within the Harvard system, where, I assume, the letter plays a less important role than it does in other hospitals. Students whose letters I estimate to be second or third line recommendations sometimes achieve magnificent internships within the Harvard system and vice versa. This suggests to me that something is apparent locally which is not reflected in the letter.

At Cornell, the Internship Advisory Committee does make an effort to identify in its letters the handful of students that are outstanding and the other handful that are mediocre, and split the rest of the class into superior and average categories. This in practice is not all that hard, despite the fact that we grade on a pass, honors, and fail system; the students see their assessments and, I believe, generally concur. The students' advisors can generally predict fairly well the type of internship that the student will achieve. The letters are reviewed for uniformity before they are sent out.

One can argue about the validity of trying to assess qualities of students. Nonetheless, I do feel (I speak for myself, not for the committees), that it is preferable for reviewers of applications to have some idea of the student's relative capacity, outlined by a summary paragraph in the Dean's letter. Contrary to an opinion expressed in the article, I do feel that Harvard is worse than most of the schools in providing useable recommendations for its students.

Michael D. Lockshin '63

Origins of the JCRT

Sid Lee's addendum to the history of the Joint Center for Radiation Therapy in the correspondence section of the May/June issue still tells only part of the story. What he described was the admirable cooperation among the Beth Israel Hospital, the New England Deaconess Hospital, the Children's Hospital Medical Center, and the Children's Cancer Research Foundation that led to the building of the Shields Warren Radiation Laboratories. However, that structure has never been used for radiation therapy. In fact, since there is no way to get a bed into the dungeons beneath the building, it was never intended to be used for radiation therapy. Future historians should know how the *therapy* parts of the Center were put together, and the institutions that took the plunge into that enterprise should receive proper credit.

After the Warren Laboratory was built, the search for a professor of radiation therapy began. However, if the new professor was clinically oriented (and all agreed he should be), he would obviously have to control a radiation therapy facility. Six hospitals in the Longwood area were so equipped: the four mentioned above, the Boston Hospital for Women, and the Peter Bent Brigham. A plan was proposed to pool all the radiation therapy facilities under the direction of the new professor with the hospitals sharing the costs of the center. The latter included the salaries of the technical and professional staff and of the professor himself. (HMS contributed its good offices, but no money. The School did offer to take the hospitals' money and pay it to the professor with an HMS check, but this was politely declined.)

After months of discussion among the hospitals, the moment of truth was reached at a luncheon meeting attended by these six directors: Mitch Rabkin of the BIH, Leonard Cronkhite of CHMC, the late Sidney Farber of CCRF, Don Lowry of the Deaconess, Bill Hassan of the PBBH, and me from the BHW. It was agreed that there comes a point in every engagement when the swain must either back out or march to the altar and say, "I do." We therefore went around the table: Rabkin, Lowry, Hassan and Freymann said "I do." Drs. Cronkhite and Farber replied in the negative. I do not remember their reasons, but that is not important. It is important that credit be given to the four institutions that did pledge their money and equipment and gave up part of their autonomy to make the Joint Center for Radiation Therapy possible. If that had not been done in the first place, Dr. Hellman's magnificent achievement would not have been possible.

John G. Freymann '46

The matching machines

I was very interested by Dr. Graettinger's article in the May/June HMAB, on the early history of the NIRMP matching program. When I wrote the computer programs to modernize the system in 1970 I was unaware of Harvard's previous involvement and the use of MGH card sorters in the first implementation of the system.

Jan Polissar '61